STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility-provided documentation, and interviews with staff and the resident representative, it was determined the facility failed to ensure that the resident representative was fully informed, in advance and in sufficient detail, by the physician or other practitioner, of the resident's condition, the risks and benefits of proposed treatment, and available treatment alternatives, in order to make an informed decision regarding care. This failure occurred for one of three closed records reviewed (Resident 98).Findings include:According to the National Institute of Health (NIH) and National Library of Medicine, Informed Consent is defined as the cornerstone of medicine, ensuring ethical treatment decisions and patient-centered care. Patients have the right to make informed and voluntary treatment decisions. Informed consent is more than merely a signature on a document; it is a communication process between the clinician and the patient. This process ensures that the patient is fully informed about the nature of the procedure or intervention, the potential risks and benefits, and the alternative treatments available. A clinical record review revealed Resident 98 was admitted to the facility on [DATE], with diagnoses that include chronic obstructive pulmonary disease (COPD, a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A clinical record review further revealed Resident Representative 1 was identified as Resident 98's responsible party/guarantor (the person legally and financially responsible for decisions and payment), substitute decision maker, and primary emergency contact. A review of Resident 98's admission agreement showed Resident Representative 1 signed the agreement on behalf of the resident. The admission agreement stated the facility's commitment to provide professional care and included resident rights, specifically the right to be fully informed in advance about care and treatment, to participate in care planning, and to be informed in advance of any changes in treatment. The agreement further stated the resident, or representative has the right to be informed, in advance and in understandable language, by the physician or other practitioner, of the risks and benefits of proposed care, treatment alternatives, and available treatment options, and to choose the preferred option. A review of Resident 98's admission agreement with the facility revealed Resident Representative 1 signed Resident 98's admission agreement as the resident representative. Further review of the admission agreement revealed the facility is committed to providing professional care and support services that will accommodate residents' medical and personal care service needs. By law you have the following rights: Freedom of Choice-Sec. 1919(c)(1): You have the right to be fully informed in advance about the care and treatment you will receive, to participate in planning your care and treatment, and to be fully informed in advance of any changes in your care plan or treatment.A review of Resident 98's admission agreement with the facility revealed section (c) Planning and (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implementing Care. The resident has the right to be informed of and participate in his or her treatment, including: The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to his or her medical condition. The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The right to be informed, in advance, of the care to be furnished and the type of caregiver or professional that will furnish care. The right to be informed in advance, by the physician or other practitioner of the profession, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options, and to choose the alternative or option he or she prefers. A review of an external Advanced Practice Nurse (APN) notes dated November 25, 2025, at 7:19 PM, revealed Resident 98 was evaluated following a fall with head strike. An APN (a licensed clinician with advanced education and training authorized to assess patients and recommend medical treatment) conducted the assessment through clinical review and video observation. The APN documented the resident's past medical history included dementia (a condition that affects memory, judgment, and the ability to understand and communicate information). The note indicated the resident experienced an unwitnessed fall from standing to the floor, striking her head, and was observed to have a golf-ball-sized mass on the head. The resident was noted to be taking aspirin (an antiplatelet medication that reduces the ability of blood platelets to stick together, which increases the risk of bleeding) and Plavix (another antiplatelet medication that also reduces platelet aggregation and increases bleeding risk). Examination findings, based on nursing assessment and video observation by APN, indicated the resident was alert and responsive and had a large, round mass approximately the size of a fist in the parietal area of the head (the side and top portion of the skull). The APN documented diagnoses of localized swelling, mass, and lump of the head and determined the resident required a computed tomography (CT) scan (a diagnostic imaging test that uses X-rays and computer technology to create detailed images of internal body structures) to rule out an acute intracranial hemorrhage (a life threatening condition involving bleeding inside the skull). The APN documented the condition was an acute new problem, assessed it as critical, recommended reevaluation of the resident's fall-risk care plan, and obtained physician orders for transfer to the emergency department.A review of a progress notes dated November 25, 2025, at 8:11 PM, documented the resident was in the dining room when the resident attempted to stand, became unsteady, and fell to the floor, striking the back of the head. The note documented the registered nurse supervisor was notified and assessed the resident. Vital signs were obtained, an ice pack was applied to the back of the resident's head, and neurological checks (routine monitoring for signs and symptoms of head or brain injury such as changes in level of consciousness, pupil response, strength, or sensation, were initiated. The nurse documented the resident's pupils were equal and reactive, the resident had full range of motion, and no signs or symptoms of pain or discomfort were observed at that time. The progress notes further documented that an external advanced practice nurse was notified and provided an order to transfer the resident to the emergency department for further evaluation. The note indicated the resident representative was informed of the order and declined the transfer at that time. However, the progress note did not document that the resident representative was informed the resident sustained a head strike, did not document the presence or size of any head injury or head mass, and did not document that the resident representative was informed of the potential seriousness of the resident's condition, including the risk of intracranial bleeding (bleeding within the skull). The note did not document that the resident representative was informed that the hospital transfer was ordered to allow diagnostic evaluation, including a computed tomography (CT) scan of the head, to assess for possible internal injury, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nor did it document that the risks associated with refusing transfer following a head injury were explained. The progress note documented subsequent neurological checks were within normal limits. The resident was seated in a chair at the nurse's station for closer observation, and the note indicated the resident would continue to be monitored for the remainder of the shift. During a phone interview on January 30, 2026, at 11:42 AM, Resident Representative 1 explained that the facility contacted her on November 25, 2025, to inform her that Resident 98 had fallen and that an APN wrote an order to send the resident to the emergency department. Resident Representative 1 indicated she was informed that the facility did not think there was a need to send the resident to the emergency department. She further stated she was not informed that the resident struck her head, developed a fist-sized mass, was considered critical, or that the transfer was recommended to rule out a potentially life-threatening intracranial hemorrhage. During an interview on January 30, 2026, at 12:05 PM, Employee 4, Licensed Practical Nurse, stated she contacted Resident Representative 1 on November 25, 2025, to report the fall and the APN's order for emergency department transfer. Employee 4 was unable to provide documented evidence that she communicated the critical assessment, head injury findings, size of the mass, or the specific risks associated with declining transfer, including the need for a CT scan to rule out intracranial bleeding. Review of the clinical record confirmed there was no documentation that this information was communicated. During an interview on January 30, 2026, at 12:30 PM, the Nursing Home Administrator (NHA) reviewed the above information and was unable to provide documentation demonstrating the facility ensured Resident Representative 1 received sufficient, detailed information to make an informed decision regarding treatment options following the fall. Specifically, there was no documented evidence the facility communicated the APN's findings that the resident's condition was critical, involved a significant head injury, and required emergency evaluation to rule out intracranial hemorrhage. During an interview on January 30, 2026, at 12:30 PM, the above information was reviewed with the Nursing Home Administrator (NHA). The NHA was unable to provide documented evidence the facility provided detailed information to Resident Representative 1 to make an informed decision about Resident 98's treatment options after the fall on November 25, 2025. Specifically, there was no documented evidence the facility communicated the APN's findings that the resident's condition was critical, involved a significant head injury, and required emergency evaluation to rule out intracranial hemorrhage. The facility failed to ensure the resident representative was fully informed of the risks, benefits, and treatment alternatives, as required, prior to declining the recommended transfer to the emergency department, thereby limiting the resident representative's ability to make an informed decision regarding Resident 98's care. Refer F842 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.2 (d)(7) Medical director. 28 Pa. Code 211.12 (c)(d)(1)(3) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and resident and staff interviews, it was determined the facility failed to provide a clean, comfortable, and homelike environment for residents, including concerns expressed by six out of six residents during a resident group interview (Residents 46, 56, 71, 77, 83, and 94) and four out of 23 sampled residents (Residents 9, 14, 20, and 52).Findings include: An observation on January 27, 2026, at 12:07 PM in resident room [ROOM NUMBER] revealed dust, food pieces, debris, and dirt on the floor and under the window-side resident bed. An observation on January 27, 2026, at 12:09 PM in resident room [ROOM NUMBER] revealed water discoloration stains and pooling near the door side bed. Food pieces and dirt were observed under the door-side bed. The resident toilet was observed with brown stains and discolorations on the seat. The toilet dispenser roll was observed with a 2-inch gap between the metal dispenser and the wall, exposing the inside of the wall. [NAME] debris from the wall was observed on the floor underneath the toilet paper dispenser. An observation on January 27, 2026, at 12:20 PM, revealed the first floor main dining room felt cold. The wall thermostat in the main dining room was set to heat the room to 75 degrees Fahrenheit, but the wall thermometer was indicating the room temperature was 65 degrees Fahrenheit. An interview on January 27, 2026, at 12:20 PM with Residents 20 and Resident 52 who were present in the dining room for lunch stated that it is often cold in the main dining room. Resident 9 was observed to be wrapped in a blanket and stated that she needed to go back to her room right after she eats because it is too cold in the dining room. Resident 14, who was also in the main dining room for lunch, stated, Hey, turn on the heat. During an interview on January 27, 2026, at 12: 22 PM the director of maintenance confirmed that the heat was set at 75 degrees Fahrenheit but was not turning on and needed to be repaired. An observation on January 27, 2026, at 12:25 PM in resident room [ROOM NUMBER] revealed a blue fall mat with brown and gray liquid and discoloration stains. An observation on January 27, 2026, at 12:34 PM in resident room [ROOM NUMBER] revealed a broken toilet dispenser roll. The ceiling above the window-side bed was observed with a line of chipped paint extending for 3 feet. A follow-up observation on January 28, 2026, at 8:55 AM revealed that the first-floor dining room felt cold. The wall thermostat in the main dining room was set to heat the room to 76 degrees Fahrenheit, but the wall thermometer was indicating the room temperature was 63 degrees Fahrenheit. During an additional observation on January 28, 2026, at 9:15 AM, the nursing home administrator confirmed that the temperatures of four walls in the first-floor dining room were 64 degrees Fahrenheit, 62.6 degrees Fahrenheit, 61.2 degrees Fahrenheit, and 62.96 degrees Fahrenheit, respectively. During a resident group interview on January 28, 2026, at 10:00 AM, six out of six residents (Residents 46, 56, 71, 77, 83, and 94) indicated they have a concern about the cold temperatures in the facility's dining room. An observation on January 28, 2026, at 12:22 PM in the third-floor Resident Pantry revealed a counter with pink liquid discoloration stains on the counter and dripping down the brown cabinets, dirt and debris pieces on the floor, a broken electrical outlet, and three ceiling blocks with 1 foot brown water discolorations, and a missing ceiling block. Additionally, the heating/cooling unit was observed with dozens of food pieces inside the radiator fins. An observation on January 28, 2026, at 12:30 PM outside the third-floor Resident Dining room revealed white handrails with chipped and peeling paint. During an interview on January 30, 2026, at 12:30 PM, the above findings were reviewed with the nursing home administrator (NHA). The facility failed to provide a clean, comfortable, and homelike environment for residents. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, resident and staff interviews, and review of facility dietary schedules, menus, and dietary records, it was determined the facility failed to consistently maintain sufficient dietary staff to effectively carry out the functions of the food and nutrition services department. This failure resulted in meals not being consistently served at palatable temperatures, the planned menu not being followed, and the food and nutrition services department not being maintained in a sanitary manner. Findings include: Review of the facility census revealed that on January 27, 2026, the facility census was 93 residents. Resident interviews conducted during the survey, which began on January 27, 2026, and concluded on January 30, 2026, revealed multiple concerns regarding the palatability of meals (the acceptability of food based on taste, texture, smell, and serving temperature). An interview with Resident 12 on January 27, 2026, at 12:00 PM revealed the resident reported food was frequently served cold and was not palatable. An interview with Resident 26 on January 27, 2026, at 12:30 PM revealed the resident did not like the food and was tired of being served meals that were cold. An interview with Resident 30 on January 27, 2026, at 12:45 PM revealed the resident stated the facility was aware he did not like the food and that meals were consistently cold. An interview with Resident 1 on January 28, 2026, at 10:30 AM revealed the resident generally liked the food but reported it was frequently not hot enough when served. Observation of the dietary department on January 28, 2026, at 12:00 PM, along with review of the facility's Daily Food Temperature Logs (recorded at each meal) for January 19 through January 28, 2026, revealed required meal temperatures were not consistently recorded. Breakfast and lunch temperatures were not documented on January 19, January 24, January 25, January 26, and January 27, 2026. Breakfast temperatures were also not recorded on January 28, 2026. Interview with the Food Service Director (FSD) at that time confirmed food temperatures were required to be recorded for each meal. A test tray evaluation was conducted on the Third Floor Nursing Unit on January 28, 2026, during the lunch meal. The test tray arrived at the nursing unit at 12:16 PM and consisted of a hot dog on a bun, corn, pork and beans, ice cream, milk, and coffee. The meal was served on Styrofoam plates, and coffee was served in a thermal mug. At 12:28 PM, after the last resident had been served, food temperatures were taken and revealed the following: Hot dog on bun measured 111 degrees Fahrenheit, below the required minimum hot holding temperature of 135 degrees Fahrenheit.Corn measured 106 degrees Fahrenheit, below the required minimum hot holding temperature of 135 degrees Fahrenheit.Pork and beans measured 122.6 degrees Fahrenheit, below the required minimum hot holding temperature of 135 degrees Fahrenheit. The hot dog, corn, pork and beans tasted only lukewarm and were not palatable. Review of dietary staffing schedules revealed limited staffing levels relative to the facility census and workload. On January 27, 2026, the dietary department schedule included one morning cook from 5:30 AM to 2:00 PM, one evening cook from 11:00 AM to 7:30 PM, one dietary aide from 6:30 AM to 1:00 PM, one dietary aide from 11:30 AM to 6:00 PM, one dietary aide from 4:00 PM to 8:00 PM, and one dietary aide assigned to assist with food delivery and storage (truck), with no specific hours identified. Review of dietary staffing schedules for January 28 and January 29, 2026, revealed similar staffing patterns, consisting of one morning cook, one evening cook, and three dietary aides covering staggered shifts, with no increase in staffing despite meal service demands. Review of the planned menu for Week Four; Friday, revealed the planned dessert was a blonde chocolate chip brownie (non-chocolate counterpart to a traditional brownie). Observation of the tray line during the lunch meal on January 30, 2026, at 11:55 AM revealed the dessert served was a vanilla cake with a wet glazed frosting that did not appear appetizing. Interview with the Food Service Director at that time confirmed the planned dessert was not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	prepared and stated he had prepared the incorrect dessert. Interview with the Food Service Director on January 30, 2026, at 12:00 PM revealed that dietary staffing hours were reduced on December 30, 2025. The FSD confirmed dietary aides for the supper meal were reduced from three aides and a cook to two aides and a cook, despite no significant decrease in resident census. The FSD stated that due to the reduction in staffing, he frequently assists with cooking and production duties. The FSD further acknowledged there were sanitation concerns within the kitchen and confirmed he was behind on ensuring completion of required food temperature logs and cleaning assignments necessary to maintain a sanitary food service environment. Interview with the Nursing Home Administrator (NHA) on January 30, 2026, at 1:00 PM confirmed that on December 30, 2025, the corporation reduced total daily dietary staffing hours, including cooks, dietary aides, and the Food Service Director, from approximately 48 to 51 total hours per day to approximately 40 hours per day. The NHA acknowledged that following the reduction, the Food Service Director was required to cook and assist with meal production more frequently due to decreased staffing levels. The facility failed to maintain sufficient dietary staffing to ensure meals were prepared and served in a sanitary manner, served at palatable temperatures, and served as planned according to the established menu. Refer F804, F812 28 Pa. Code 201.14(a)(b) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1) Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, review of select facility policies, test tray evaluation, review of facility-provided documentation, and resident and staff interviews, it was determined the facility failed to ensure foods were served at safe and palatable temperatures for four of 23 residents sampled (Residents 12, 26, 30, and 1).Findings included: According to the federal regulation 483.60(i)-(2) Food safety requirements, the definition of Danger Zone, found under the Definitions section, is food temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow rapid growth of pathogenic microorganisms that can cause foodborne illness. Review of the facility Safe Food Handling Practices Policy last reviewed January 23, 2026, revealed that hot food must be held at 135 degrees Fahrenheit or higher and cold foods must be held at 41 degrees or lower. During an observation of the dietary department on January 26, 2026, at 10:00 AM, the facility's dishwasher was observed to be inoperable. During an interview at that time, the Food Service Director (FSD) stated the dishwasher had been broken for approximately one month and confirmed that disposable paper products and plastic silverware were being used for resident meal service. A review of facility-provided information revealed the dishwasher malfunctioned and became inoperable on November 21, 2025. A review of Resident Food Committee Meeting Minutes dated December 25, 2025, revealed residents expressed concerns that the dishwasher had not yet been repaired and reported that food was being served cold. A subsequent review of Food Committee Meeting Minutes dated January 14, 2026, revealed residents continued to voice concerns that the dishwasher remained unrepaired and requested that hot foods be served on plates rather than Styrofoam. During an interview on January 27, 2026, at 12:00 PM, Resident 12 stated that meals were frequently served cold and not palatable and reported meals being served on Styrofoam containers for several months due to the broken dishwasher. During an interview on January 27, 2026, at 12:30 PM, Resident 26 stated dissatisfaction with the food and reported being tired of receiving cold meals. During an interview on January 27, 2026, at 12:45 PM, Resident 30 stated the facility was aware he did not like the food and reported that meals were always cold. During an interview on January 28, 2026, at 10:30 AM, Resident 1 stated they liked the food but reported it was frequently not hot enough. A test tray evaluation was conducted on the Third Floor Nursing Unit on January 28, 2026, during the lunch meal. The test tray arrived on the unit at 12:16 PM and consisted of a hotdog on a bun, corn, pork and beans, ice cream, milk, and coffee. The meal was served in Styrofoam containers, with coffee served in a thermal mug. At 12:28 PM, after the last resident on the unit was served, food temperatures were measured and recorded as follows:Hotdog on bun: 111 F (below the required minimum of 135 F)Corn: 106 F (below the required minimum of 135 F)Pork and beans: 122.6 F (below the required minimum of 135 F) The hot dog, corn, pork and beans tasted only lukewarm and were not palatable. During an interview on January 28, 2026, at 1:15 PM, the Food Service Director confirmed that meals are required to be served at safe and appetizing temperatures and acknowledged that the test tray temperatures did not meet facility policy or regulatory requirements. A review of Test Tray Audits completed by the Registered Dietitian (RD) on November 21, 2025 (third floor lunch), November 28, 2025 (third floor lunch), December 4, 2025 (second floor lunch), December 12, 2025 (third floor lunch), January 9, 2026 (third floor lunch), and January 15, 2026 (second floor lunch) revealed that multiple hot food items were documented as not being served at palatable temperatures During an interview on January 29, 2026, at 1:40 PM, the Registered Dietitian confirmed that complaints related to cold food had increased since the dishwasher became inoperable. During an interview on January 29, 2026, at 2:30 PM, the Nursing Home Administrator confirmed the facility failed to ensure meals were consistently served at temperatures that were palatable and in accordance with regulatory requirements. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer F80228 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(3) Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview, it was determined the facility failed to ensure the provision of adaptive dining equipment as prescribed to support safe eating for one of 23 sampled residents. (Resident 16)Findings include: A review of the clinical record revealed that Resident 16 was admitted to the facility on [DATE], with diagnoses to include cerebral palsy (group of permanent movement, muscle tone, or posture disorders caused by abnormal brain development or damage before, during, or shortly after birth) and dysphagia (difficulty swallowing). Review of a quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 2, 2025, indicated that a BIMS interview (Brief Interview for Mental Status, a tool to assess cognition) should not be completed with the resident due to the resident being rarely or never understood, had short term and long term memory problem, was severely cognitively impaired for decision making, and was dependent on staff for eating. A physician order dated April 4, 2024, noted an order for a coated spoon (protects teeth and prevents minor injuries to the gums and lips) with all meals. Review of Resident 16's January Task Documentation Report between the dates of January 1, through January 28, 2026, revealed the coated spoon was not provided with meals for 31 out of 84 meals served. Observation during the lunch meal on January 29, 2026, at 12:30 PM revealed a coated spoon was indicated on the resident's tray ticket. However, a plastic disposable spoon was provided on the resident's tray. Interview with Employee 9 Nurse Aide at this time confirmed the coated spoon was not provided. Employee 9 confirmed the coated spoon was frequently not provided on the resident's tray. Employee 9 revealed the resident at times bites down on the spoon while feeding and having the coated spoon is beneficial to the resident. During an interview on January 29, 2026, at approximately 1:30 PM the Nursing Home Administrator acknowledged the facility failed to ensure the prescribed adaptive equipment (coated spoon) was consistently provided to the resident with meals and used in accordance with the physician's orders. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of select facility policy, and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of foodborne illness in the food and nutrition services department and failed to ensure that food storage in personal refrigerators was adequately monitored and maintained within safe temperatures to prevent foodborne illness for one resident with a personal refrigerator (Resident 5).Findings include:Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).Review of the food and nutrition services department's Food Temperature Logs Policy last reviewed January 23, 2026, indicated that food temperatures of cold and hot items will be recorded on all menu items for meal service. Observation on January 27, 2026, at 10:00 AM, during the initial tour of the food and nutrition services department conducted with the Food Service Director (FSD), revealed multiple unsanitary conditions. Dirt and debris were observed on the floor throughout the kitchen. Two uncovered sheet cakes were observed on a rolling rack inside the walk-in refrigerator. The ceiling vent located above the ice machine was visibly dust covered, and two ceiling tiles adjacent to the dishwasher were heavily stained. Interview with the FSD at this time revealed the dishwasher had been broken for about one month. The FSD stated that paper products and plastic silverware were being used for meal service. The FSD confirmed that the three compartment sink (commercial kitchen fixture with three basins for manually washing, rinsing, and sanitizing dishes and utensils in distinct stages, following health code standards by using hot, soapy water for washing dishes at a temperature of 110 degrees Fahrenheit, clean water for rinsing, and a chemical sanitizer, with items then air dried on a nearby drainboard to prevent contamination) was being utilized to clean and sanitize the non-disposable kitchen equipment. Review of facility provided documentation revealed the dishwasher became inoperable on November 21, 2025. Documentation further showed a lease for a replacement dishwasher was signed on November 24, 2025, and the facility was awaiting delivery and installation of the new unit.Observation on January 30, 2026, at 10:25 AM, revealed the new dishwasher was in place but not operational, as it was awaiting electrical serviceObservation on January 28, 2026, at 12:00 PM, revealed an accumulation of dirt and debris underneath the tray line area. Observation on January 30, 2026, revealed four food delivery carts identified as clean had visible food stains on both the interior and exterior surfaces. Observation of the steam table at that time revealed water in the individual wells contained food debris from prior meals. The FSD stated the steam table water was changed weekly. Review of facility records revealed there were no documented cleaning schedules available for the months of December 2025 or January 2026. During an interview on January 30, 2026, at 10:40 AM, the FSD confirmed the food and nutrition services department was expected to be maintained in a sanitary manner and that facility policies and procedures were to be followed to ensure food safety and prevent foodborne illness. Review of the facility's Daily Food Temperature Logs from January 19 through January 28, 2026, revealed incomplete documentation. Breakfast and lunch food temperatures were not recorded on January 19, January 24, January 25, January 26, and January 27, 2026. Breakfast temperatures were also not recorded on January 28, 2026. During an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interview conducted on January 28, 2026, the FSD confirmed food temperatures were required to be monitored and recorded at each meal. Review of the facility's Resident Refrigerators policy last reviewed January 23, 2026, revealed that it was the policy of the facility to ensure safe and sanitary use of any resident owned refrigerator. Leftover food will be dated upon receipt and discarded within three days. Nursing and housekeeping were to discard any food that was out of compliance during the minimal weekly checks, which was to include assessing properly dated food items and discarding what was outdated, and monitor refrigerator temperatures.During an interview on January 27, 2026, at 11:00 AM, Employee 7 Licensed Practical Nurse stated Cooler Temperature Logs were posted on the outside of resident refrigerators and nursing or housekeeping staff were responsible for monitoring and documenting internal refrigerator temperatures daily. Observation of Resident 5's personal refrigerator located in the resident's room on January 27, 2026, at 11:00 AM, revealed a covered plastic container of food without a date indicating when it was placed in the refrigerator. Employee 7 was unable to identify how long the food had been stored or whether the three-day discard timeframe had been exceeded. Observation of the Cooler Temperature Log posted on the outside of Resident 5's refrigerator on January 27, 2026, at 11:00 AM, revealed the last documented internal refrigerator temperature was recorded on August 1, 2025. During an interview on January 28, 2026, at 9:00 AM, the nursing home administrator was unable to provide additional information to demonstrate staff consistently monitored and documented resident refrigerator temperatures or ensured food was properly labeled and discarded to prevent foodborne illness.Refer F802 28 Pa Code 201.18 (e) (2.1) Management. 28 Pa Code 211.6(f) Dietary services. 28 Pa Code 211.10 (a)(d) Resident care policies. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility-provided documentation, and employee interviews, it was determined the facility failed to ensure the accuracy and completeness of resident medical records for one of 3 closed records (Resident 98). Findings include:Review of the clinical record revealed that Resident 98 was admitted to the facility on [DATE], and subsequently transferred to the emergency department on November 28, 2025. Following a fall on November 25, 2025, neurological check assessments (routine monitoring for signs and symptoms of head or brain injury) were initiated for Resident 98. Review of these neurological assessments revealed a total of 21 assessments were documented as completed. However, the electronic clinical record indicated the neurological assessment documentation was not finalized or locked until January 7, 2026. A lock date represents the point at which documentation is finalized and made read-only to prevent further alteration. Further review revealed that 13 of the 21 neurological assessments were not signed as completed until after Resident 98 had already been transferred to the emergency department on November 28, 2025. Additional record review revealed the presence of late-entry progress notes. A progress note dated November 27, 2025, at 11:29 AM documented that Resident 98 was awake, alert, oriented to self, and confused per baseline; however, the electronic record indicated this note was created on November 30, 2025, at 2:31 PM. Similarly, a progress note dated November 28, 2025, at 10:37 AM documented that the resident was awake, alert, oriented to self, and confused per baseline, yet the electronic record showed this note was created on November 30, 2025, at 2:38 PM. In addition, the facility provided a certified registered nurse practitioner (CRNP) progress note dated November 26, 2025, and signed at 5:27 PM. This note was not uploaded into Resident 98's electronic clinical record. The facility also provided an amended version of the CRNP progress note dated November 26, 2025, and signed on November 28, 2025, at 6:33 PM; this amended note was likewise not uploaded into the resident's electronic clinical record. During an interview conducted on January 30, 2026, at 12:30 PM, the above findings were reviewed with the nursing home administrator (NHA). The NHA explained that facility staff were temporarily covering the duties and responsibilities of the medical records practitioner while the facility was in the process of arranging consultative medical records services. These findings demonstrated that the facility failed to ensure Resident 98's clinical record was accurate, complete, and reliably maintained. Refer F55228 Pa. Code 211.5 (f)(ii)(iii)(iv)(x)(i) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.